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Current Practice Patterns of US Radiation Oncologists Treating Head and Neck Cancers

Rohi Gheewala, BS; Michael Lee; Wencesley A. Paez, MD, MSHS; Jong Kim, PhD; Timur Mitin, MD, PhD; Ravi Chandra, MD, PhD
gheewala@ohsu.edu
OHSU School of Medicine

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Abstract

Background

Current practice patterns of US radiation oncologists remain largely unknown. Associations between hierarchy of decision-making for transoral robotic-assisted surgery (TORS) versus definitive chemoradiation (CRT), use of prophylactic percutaneous endoscopic gastrostomy (pPEG), and time of PEG removal with demographic characteristics of practicing radiation oncologists are studied.

Method

A 12-question survey was distributed to 4,500 US board-certified radiation oncologists and included questions on demographics and management. Pearson Chi-square, Fisher's exact, and Log likelihood ratio tests were used to conduct univariate and multivariate analyses.

Results

A total of 303 responses were received. Respondents (91%) believed that HNC patient volume had either remained the same or increased during the past 5 years. The two most common responses to induction chemotherapy site were none (54%) and nasopharynx (24%). Nearly half of generalists (48%) and respondents in private practices (49%) provided pPEG for more than a quarter of their patients, as compared to few HN specialists (19%) and respondents in academic settings (24%) ($p=0.00$ and $p=0.00$, respectively). Respondents most commonly (65%) removed PEG tubes within one to three months, however, a significant proportion of generalists (38%) and multi-specialists (30%) removed PEG tubes after 3 months ($p=0.00$). Multidisciplinary management was more common for HN specialists (39%) and in academic settings (29%), and less common for generalists (13%) and in private practices (14%) ($p=0.05$ and $p=0.02$, respectively), although only one-fifth (20%) of overall respondents reported using multidisciplinary care.

Conclusion

Management of HNC was dependent on demographic characteristics of practicing US radiation oncologists. Specialists and academic practice settings were associated with multidisciplinary treatment decision-making, lower use of pPEG, and early removal within one to three months, potentially attributed to less frequent pPEG use, as compared to generalists and private practice settings. Increased multidisciplinary collaboration, academic-community partnerships, and PEG placement protocols are needed to standardize HNC management.